Arkansas State Board of Nursing

University Tower Building
1123 South University Avenue, Suite 800
Little Rock, Arkansas 72204

PHONE 501.686.2700
FAX 501.686.2714
www.arsbn.org

INSTRUCTIONS FOR COMPLETION OF CERTIFICATE OF PRESCRIPTIVE AUTHORITY ENDORSEMENT APPLICATION

TO: Advanced Practice Nurse

You may be eligible to apply for a Certificate of Prescriptive Authority through endorsement. Please read the following information carefully.

REQUIREMENTS

1. You must have an unencumbered advanced practice nursing license to practice in Arkansas.
2. You must contact the Board of Nursing in the jurisdiction where you have prescribing privileges and have a notarized Advanced Practice Verification Form (form attached) completed by and sent directly from the Board of Nursing in the jurisidiction where you have current prescribing privileges. You probably have already completed this form when you applied for your advanced practice license.
3. You must submit documentation of a three (3) graduate credit hour pharmacology course offered by an accredited college or university or a forty-five (45) contact hour (a contact hour is fifty (50) minutes) pharmacology course which includes a competency component offered by an accredited college or university.
4. You must submit notarized evidence of a minimum of five hundred (500) hours of **prescribing** in a clinical setting in the year prior to application.
5. You must submit an original, current collaborative practice agreement (sample attached) with an Arkansas licensed physician who has a practice comparable in scope, specialty or expertise to yours. The collaborative practice agreement shall include, but not be limited to:
   a. Availability of the collaborating physician(s) for consultation or referral, or both;
   b. Methods of management of the collaborative practice, which shall include the use of protocols for prescriptive authority;
   c. Plans for coverage of the health care needs of clients (where clients are referred to) in the emergency absence of the advanced practice nurse:
   d. Plan for coverage (with whom an APN will consult) in the emergency absence of the collaborating physician;
   e. Signatures of the advanced practice nurse and collaborating physician(s), stating their signatures signify mutual agreement to the terms of the collaborative practice. (If signatures are on a separate sheet from the agreement, include this statement on the sheet with signatures.)
   f. Arkansas medical license number and specialty of collaborating physician;
   g. Work site name(s), address(es), and phone number(s);
   h. Collaborating physician's work site address (if different from your work site); and
   i. Statement that APN will limit prescribing to area of educational preparation and certification.
6. You must submit a copy of current DEA registration and a list of DEA numbers used (if prescriber has DEA number) and history of registration status.
7. Quality Assurance Plan to be submitted with the collaborative practice agreement. Go to ASBN Web site, www.arsbn.org, and click on "Advanced Practice" and locate Quality Assurance Guidelines for APNs.
8. You must submit a completed, notarized application and appropriate fee of $150.00 (application will be returned if all areas are not completed). **FEES ARE NON-REFUNDABLE.**

FALSIFICATION OF THIS FORM IS GROUNDS FOR DISCIPLINARY ACTION AGAINST YOUR LICENSE.

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LITTLE ROCK, ARKANSAS 72204
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FOR OFFICE USE ONLY

CERTIFICATE OF PRESCRIPTIVE AUTHORITY APPLICATION

Full Name _____
(MISS, MS, MRS, OR MR) FIRST MIDDLE MAIDEN LAST

Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET/P.O. BOX CITY STATE ZIP

Social Security No. _____ E-mail address _____ Telephone No. (____) _____

Birthdate _____ RN License # _____ APN License # _____
Month/Day/Year

Practice Setting Name _____ Telephone No. (____) _____

Practice Setting Address _____
Street City State ZipCode

Currently Certified As:
ANP ☐ CRNA ☐ CNS ☐ CNM ☐

Certifying Body _____ Exam Title _____

Advanced Practice Nursing Program _____

Have you ever been convicted of a misdemeanor or felony, pled guilty or nolo contendere to any charge in any state or jurisdiction? DWI's and similar offenses must be reported. (Traffic violations do not constitute a crime.) YES ☐ NO ☐
(If yes, include a certified copy of the court docket, plea agreement, or conviction papers, and evidence that fines, restitution are paid.)

Have you ever had any license, certificate, registration, or privilege to practice disciplined (revoked, suspended, placed on probation, or reprimanded) or voluntarily surrendered in any state or jurisdiction? YES ☐ NO ☐
(If yes, include copy of Facts and Finding from Board and evidence of reinstatement of license.)

Are you currently under investigation in any state or jurisdiction? YES ☐ NO ☐

Do you currently engage in drug-related behavior, including the use of mood-altering drugs/substances and/or alcohol that would affect your functional abilities to perform while working as a nurse? YES ☐ NO ☐

In the last two years, have you been the subject of a chemical or alcohol dependency intervention or participated in chemical or alcohol dependency treatment/rehabilitation? YES ☐ NO ☐
(If yes, submit all relevant documents, such as rehab program completion, support group meetings, drug screens, etc.)

ENDORSEMENT APPLICANTS ONLY:

Have you ever had a DEA number? YES ☐ NO ☐ (*If yes, please provide a copy of current DEA registration and list all numbers ever used)*

Has DEA registration ever been denied, limited, suspended, or revoked? YES ☐ NO ☐
(If yes, submit all relevant documents.)

(over)

FOR OFFICE USE ONLY
Certificate Number _____
Date Issued _____

Certificate of Prescriptive Authority $150.00

METHOD OF PAYMENT

☐ In-state personal check

☐ Money order/cashiers check

☐ Credit card

FEE IS NONREFUNDABLE

CREDIT CARD INFORMATION

Complete below if paying by credit card. There is a nominal processing fee (listed below) assessed with paying your fees by credit card. The Arkansas State Board of Nursing does not receive any portion of the processing fee.

Type of card Visa ☐ MasterCard ☐ Discover ☐

Cardholder's Name _____

Cardholder's billing address _____

_____

Credit Card # _____

Expiration date _____/_____ Amount Paid _____
mm yyyy

Signature _____

*Processing fee - Certificate of Prescriptive Authority - $4.50

AFFIDAVIT

State of _____

County of _____

If, after a certificate has been issued on this application, it is ascertained that misrepresentation of facts or fraudulent statements have been made, the certificate so issued shall be revoked by the Board of Nursing and the applicant becomes subject to legal prosecution

I, _____, being duly sworn or affirmed, say that I am the person referred to in the foregoing application for a certificate of prescriptive authority in the State of Arkansas that the statements herein contained are true in every respect; that I agree to comply with all requirements of the law, including all state and federal laws and regulations regarding prescribing; and that I have read and understand this affidavit.

_____
Applicant's Signature

Sworn to before me this_____day of _____, 20 _____
My Commission Expires_____, 20 _____

_____, Notary Public
SIGNATURE

NOTARY
SEAL

ARKANSAS STATE BOARD OF NURSING

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Collaborative Practice Agreement with a Single Physician

Advanced Practice Nurses (APNs) with Prescriptive Authority must have a current updated Collaborative Practice Agreement (CPA) on file with the Board of Nursing. APNs should keep their original CPA and provide the Board with a copy submitted via fax, mail, or scanned/emailed. The APN is responsible for ensuring this requirement is met.

The APN must notify the Board in writing the first business day after the CPA is terminated. If the Board does not have a current CPA on file, the APN's Prescriptive Authority will be inactivated. When a new CPA has been approved by Board staff, Prescriptive Authority is reactivated. After approval of any new CPA, the APN will be contacted by mail that the CPA has been approved and in effect.

The Collaborative Practice Agreement must meet the following criteria:

1. Must be complete and legible
2. The collaborating physician must have a current AR license to practice under the Medical Practice Act, § 17-95-201. The collaborating physician must also have an unrestricted DEA registration number for APNs who prescribe controlled substances.
3. The collaborating physician's practice must be comparable in scope, specialty, or expertise to that of the APN's practice/specialty.
4. Must include a statement that "APN's prescribing will be limited to the area of educational preparation and certification."
5. Provision addressing availability of the collaborating physician for consultation and/or referral
6. Method of management of the collaborative practice (include a statement regarding protocols for Prescriptive Authority)
7. Plans for coverage of the health care needs of the patient in the emergency absence of the APN or collaborating physician
8. Provision for quality assurance (attach the Quality Assurance Plan that has been signed by the APN and the collaborating physician).
9. Signatures of both the APN and the collaborating physician
10. If signatures are on a separate sheet from the agreement, a statement indicating that there is mutual agreement to the terms and conditions of the CPA must be included on the signature page (so that it is clear what the signature indicates).
11. License numbers and certification specialties of both the APN and the collaborating physician
12. Address and phone number of the APN's and physician's practice site(s)

See the next page for an example of a Collaborative Practice Agreement that meets the ASBN's criteria. If you choose to list more than one physician, please use the "Collaborative Practice Agreement with Multiple Physicians" document.

Collaborative Practice Agreement with a Single Physician

This agreement is for the management of the collaborative practice between

_____, APN and _____, MD.

The physician hereby agrees to be available to the Advanced Practice Nurse (APN), either in person or via electronic or telephonic communication, for consultation and referral. Mutually agreed upon protocols for Prescriptive Authority will be utilized by the APN as a guide for general categories of health states. The APN shall limit prescribing to the area of educational preparation and certification as noted below.

Should an emergency arise, necessitating the absence of the APN or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity. Until that time, _____ with which the
(hospital)
collaborating providers are associated, provides emergency services 24-hours daily for the clients of _____.
(clinic)

There is a written provision for quality assurance (attach the Quality Assurance Plan).

This agreement of professional collaboration is by no means intended as a business contract but rather as a document that fulfills the requirements for Prescriptive Authority as set forth in the Arkansas *Nurse Practice Act*. The signatures below signify agreement to the terms of the collaborative practice.

_____, APN

Print name_____

Practice Site_____

APN AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

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3. The collaborating physician's practice must be comparable in scope, specialty, or expertise to that of the APN's practice/specialty.
4. Must include a statement that "APN's prescribing will be limited to the area of educational preparation and certification."
5. Provision addressing availability of the collaborating physician for consultation and/or referral
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Should an emergency arise, necessitating the absence of the APN or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity. Until that time, _____ with which the
(hospital)
collaborating providers are associated, provides emergency services 24-hours daily for the clients of _____.
(clinic)

There is a written provision for quality assurance (attach the Quality Assurance Plan).

This agreement of professional collaboration is by no means intended as a business contract but rather as a document that fulfills the requirements for Prescriptive Authority as set forth in the Arkansas *Nurse Practice Act*. The signatures below signify agreement to the terms of the collaborative practice.

_____, APN

Print name_____

Practice Site_____

APN AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

Collaborative Practice Agreement with Multiple Physicians

The signatures below signify mutual agreement to the terms of the Collaborative Practice Agreement.

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

_____, MD

Print name_____

Practice Site_____

☐ Practice site same as APN

MD AR License #_____

Area of certification_____

Practice Address_____
(Street)

_____
(City) (County) (Zip)

MUST BE ON COMPANY
OR PHYSICIAN LETTERHEAD

FROM: _____

_____

_____

DATE: _____

TO: ARKANSAS STATE BOARD OF NURSING

THIS LETTER IS TO PROVIDE EVIDENCE THAT _____, APN
(print name)

HAS COMPLETED A MINIMUM 500 HOURS PRESCRIBING IN A CLINICAL SETTING IN THE YEAR IMMEDIATELY

PRIOR TO APPLICATION FOR PRESCRIPTIVE AUTHORITY.

_____
DATE LAST WORKED

_____
SIGNATURE OF PHYSICIAN OR EMPLOYER

_____
(print name)

NOTARY SEAL

NOTE: THIS FORM IS <u>ONLY</u> FOR ADVANCED PRACTICE APPLICANTS SEEKING ENDORSEMENT OF THEIR PRESCRIPTIVE AUTHORITY FROM ANOTHER JURISDICTION.

i

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PRESCRIPTIVE AUTHORITY VERIFICATION FORM

COMPLETE PART 1 AND FORWARD THIS FORM TO THE BOARD OF NURSING IN THE JURISDICTION WHERE YOU HAVE PRESCRIPTION PRIVILEGES.

PART 1:

Name (Last, First, Maiden/Middle):		
Street Address		
City	State	Zip Code
RN License Number	Advanced Practice License Number	Prescriptive Authority Number

PART 2:

THE ABOVE NAMED PERSON HAS APPLIED FOR A CERTIFICATE OF PRESCRIPTIVE AUTHORITY BY ENDORSEMENT. PLEASE COMPLETE AND RETURN TO:

Arkansas State Board of Nursing
University Tower Building
1123 South Uiversity Ave., Suite 800
Little Rock, AR 72204

I hereby verify that _____ (print name)
has met the initial criteria for prescriptive authority.

Is the licensee currently authorized to prescribe in your jurisdiction? Yes ☐ No ☐

Is Prescriptive Authority automatically granted with APN licensure? Yes ☐ No ☐

License/Certificate Number _____ Date of Issuance _____

Has license/certificate ever been encumbered? Yes ☐ No ☐ *If yes, please attach a certified copy of Board order*

Is applicant currently under investigation? Yes ☐ No ☐

Seal

Executive Director _____

State of _____

_____

Dated at _____ this _____ day of _____ 20_____